STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013439	A. BUILDING: _____ B. WING _____	11/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE OF MISHAWAKA	820 FULMER ROAD MISHAWAKA, IN 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for an Initial State Residential Licensure Survey. Survey dates: November 23, 2015 Facility number: 013439 Provider number: 013439 AIM number: N/A Residential census: 1 Sample: 1 Primrose of Mishawaka was found to be in compliance with 410 IAC 16.2-5 in regard to the Initial State Residential Licensure Survey. Quality Review completed by 14454 on November 24, 2015.	R 000		